County of San Bernardino Department of Public Health
DIVISION OF ENVIRONMENTAL HEALTH SERVICES

LIMITED QUANTITY HAULING EXEMPTION

Pursuant to Chapter 6.1, Division 20, of the Health and Safety Code, the following person(s) are authorized to transport regulated medical waste from the point of generation to the point of storage or treatment under the following conditions:

1. The generator or health care professional generates less than 20 pounds of medical waste per week and transports less than 20 pounds of medical waste at any one time as specified in Section 118030.
2. Your office maintains a tracking document with the required contents as specified in Section 118040 (b).
3. A copy of this exemption form and a tracking document, as described above, MUST be in the employee's possession while transporting the medical waste.
4. Your office notifies the Department of any changes in the information supplied on this form within 30 days of changes.
5. Your office submits an administrative fee of $25.00 for the initial exemption, which includes up to four names. There is an additional fee of $5.00 for each name submitted beyond the first four, up to a maximum additional fee of $25.00.
6. Your office submits a completed Preapplication Questionnaire and a statement describing your need for this exemption. Include in this statement a description of the relationship between the facility, the person transporting the waste and the point of waste consolidation.

In order to receive a LIMITED QUANTITY HAULING EXEMPTION, complete the following information and return this form for final approval to:

County of San Bernardino
Department of Public Health
Division of Environmental Health Services
Waste Management/LEA/Medical Waste
385 North Arrowhead Avenue, 2nd Floor
San Bernardino, CA 92415-0160

FACILITY NAME AND ADDRESS	REGISTERED/PERMITTED COMMON STORAGE FACILITY OR POINT OF CONSOLIDATION
Facility # _____	*(See Above)*
FAX # _____	_____
Name: _____	_____
Address: _____	_____
_____	_____
Phone Number: _____	_____

TREATMENT FACILITY IDENTIFICATION

Name: _____

Address: _____

_____

Employees authorized to transport medical waste:

1. _____ 2. _____
3. _____ 4. _____

If additional names are to be added, attach a separate sheet of paper to this form.

_____
Signature of Generator

_____
Name of Generator (Please Print)

Department Use Only

_____ , REHS
Medical Waste Management Program

Expiration Date:_____

NOTE: This exemption is valid for one year. This exemption is not valid unless both the generator of the waste and the Department have signed this form. This exemption is void if any of the conditions specified above are violated or exceeded.